**Esophagogastric Diagnostic Assessment Program (EDAP) REFERRAL FORM**

**Date of referral (yyyy/mm/dd):** __________________________

**Indication for referral:**

- ☐ Esophageal Cancer
- ☐ Gastric Cancer
- ☐ Gastroesophageal (GE) Junction Cancer
  (Encompasses all tumours with an epicentre within 5 cm proximal or distal to the GE junction)
  Tumours with epicentre located within 5 cm above to 2 cm below GE junction will be referred to an Esophageal Cancer General Surgeon.
  Tumours with epicentre located more than 2 cm below GE junction will be referred to a Gastric Cancer General Surgeon.

Please identify diagnostic interventions completed:

- ☐ Blood Work
- ☐ CT head
- ☐ MRI brain
- ☐ PET Scan
- ☐ CT Chest/Abdomen
- ☐ CT Chest/Abdomen/Pelvis
- ☐ Upper Endoscopy
- ☐ EUS
- ☐ Diagnostic Laparoscopy
- ☐ PFT

**Please include the following information with the referral, if applicable:**

- Completed referral form
- Recent blood work
- Past medical history
- Imaging reports
- Endoscopic procedure reports
- Pathology reports
- Operative reports (i.e. diagnostic laparoscopy, laparotomy, if applicable)
- Current medications (including ALL anticoagulants, antiplatelets, and NSAIDS)

**Referred by:**

- ☐ Primary Care Physician
- ☐ Nurse Practitioner
- ☐ Surgeon
- ☐ Gastroenterologist

Name: ___________________________ Phone: ___________________________ Fax: ___________________________

(please print)

Signature: ___________________________ CPSO Number: ___________________________

**Fax Number: 613-544-3319 – DAP@kingstonhsc.ca**

**EDAP Patient Nurse Navigator Telephone: 613-544-3400 extension 2411**

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CT – computed tomography  PET – positron emission tomography  MRI – magnetic resonance imaging  EUS – Endoscopic Ultrasound  PFT – Pulmonary Function Test  NSAIDS – nonsteroidal anti-inflammatory drug  CPSO – College of Physicians & Surgeons of Ontario